ENCOUNTER KEYS

AHCCCS ENCOUNTER

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NEW PLACE OF SERVICE CODES

Several new Place of Service (POS) codes became effective January 2003. AHCCCS has not yet added the new codes to the system tables; as a result, encounters reported with the new POS codes are pending for edit H780 "POS is not on file". Contractors are instructed to leave the H780 pends alone until they receive notification that the AHCCCS table updates are completed. Contractors should not deny claims billed with new POS codes solely because of the AHCCCS table issue.

AHCCCS Approves Codes and Rate for Ambulatory Surgical Center Group 9

Effective July 1, 2003 AHCCCS has approved codes and rates for Ambulatory Surgical Center (ASC) Group 9. The rate for Group 9 is $1,331. A complete list of ASC groups and the HCPCS codes that are included in each group can be downloaded from CMS at:

http://cms.hhs.gov/providers/pufdownload/ascdown.asp

Not all HCPCS codes that have been approved by CMS for inclusion in an ASC group are AHCCCS covered services. Providers should confirm that a service is covered prior to billing and Contractors should confirm prior to payment.
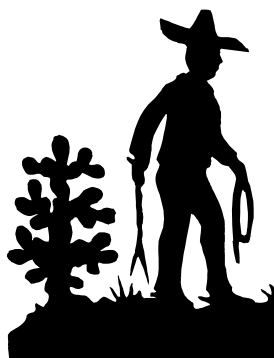
DILEMMAS

For the months of July and August the following error code conditions are not subject to sanction.

S385 – Service Units Exceed Maximum Allowed (80000 procedure codes and service units less than twice the limit).

S386 – Maximum Anesthesia Units Exceeded (Service units less than twice the limit)

CLAIM DENIALS

Claims should not be denied solely on the basis of AHCCCS reference table information. Encounters pending as a result of AHCCCS reference table information should be reviewed for data errors and, if appropriate, corrected. If data on the encounter is identical to the claim and contractor medical review staff has approved the claim, claim documentation should be forwarded to AHCCCS.

Pended encounters are resolved based on: (1) pended encounter error correction; (2) pended encounter error override; (3) pended encounter withdrawal as a result of improper billing or incorrect data; or (4) AHCCCS reference table revision.

Code Changes

- The rate for J3490 -Unclassified Drugs has been changed to $0.00, effective for dates of service on or after 04/01/2003
- L2770-Addition to Lower Extremity-Orthosis, Any Material - has been changed to a daily maximum of four (4)
- L5050 – Ankle, Symes, Molded Socket, Each Foot - Place of Service is now 12
- Marfans 759.82 - the minimum age has been removed
- Provider Type 18 - can now bill the procedure code 76857 Echograph, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete limited or follow-up (eg., for follicles)
- Provider Type 10 (Podiatrist) can now bill the following procedure codes with an effective date of 01/01/2003:
    - 76880 - Ultrasound, Extremity, Non-Vascular, B-Scan And/or real
    - 27685 - Lengthening Or Shortening Of Tendon, Leg Or Ankle
    - 27686 - Lengthening Or Shortening Of Tendon, Leg Or Ankle
    - 20694 - Removal, Under Anesthesia, Of External Fixation System
    - 97530 Therapeutic Activities, Direct (One-On-One) Patient Contact
    - 97532   Development Of Cognitive Skills To Improve Attention, Memory
    - 97535   Self-Care/Home Management Training (Eg, Activities Of Daily Living

NATIONAL DRUG CODE (NDC) INFORMATION

AHCCCS Administration's source of drug information is the Blue Book pharmacy database. If your plan's source of drug information is Red Book or Medi-Span and your plan has encounters pending for N004 - National Drug Code (NDC) Not on File, it may be a result of your source of drug information. The AHCCCS Encounter Unit can clear these pends if you provide the following information:

- ◆ Source book (RedBook or Medi-Span) & Year the Book was published
- ◆ Page number
- ◆ Description of NDC code
- ◆ Manufacturer/Labeler
- ◆ Package Quantity
- ◆ Price

Direct all NDC information to Deborah Burrell at: daburrel@ahcccs.state.az.us

S340 – PROCEDURE CODE NOT ON FILE FOR DOS

Encounters pending for S340-Procedure Code Not On File for DOS are generally a result of reporting procedure codes that have been end dated. For example, procedure code 94160 - Vital Capacity Screening Tests: Total Capacity was end dated on March 31, 1997. Reporting 94160 for and after dates of service April 1, 1997 on encounters creates an S340 pend error. The monthly reference files (refer 01 and/or refer 02) available on the FTP server contain up-to-date procedure code information.

CMS CRACK DOWN ON DIAGNOSIS CODING

CMS is cracking down on physician documentation of patient diagnoses, indicating it won't cut physicians slack anymore when it comes to reporting precise diagnosis codes on Medicare claim forms.

Program Memorandum (PM) (transmittal B-03-046) issued June 10 establishes new requirements for ICD-9-CM diagnosis coding on claims submitted to Medicare carriers and plots out an "increased role for physicians/practitioners." Physicians may see a sharp rise in claims denials unless they conform.

As stated in the June 10th PM, the PM underscores how important it is for physicians to have a greater understanding of ICD-9-CM diagnosis codes, especially as they relate to CMS policies and guidelines. Previous Medicare carriers have paid on claims that perhaps were not 100% perfect as long as they could make heads or tails of things. In this program memorandum they state that effective Oct. 1, 2003, providers will be held accountable for accurate coding -- making certain from documentation to encounter forms to orders/referrals to claims that all ICD-9-CM coding is accurate and specific supporting the documented medical necessity.

Beginning with service dates on or after Oct. 1, ICD-9-CM diagnosis codes must appear on all Medicare Part B electronic and paper claims. CMS notes that health care organizations rely on physicians for diagnosis codes or narratives on orders and referrals for treatment. This PM implements the seven-year-old requirement under HIPAA for physicians to provide diagnostic narrative or ICD-9 codes to the hospital to enable the hospital to bill for services it provided on the physician's order.

To view the PM, visit AIS's CMS/IG Library at www.AISHealth.com/Compliance/HCFAIGLibrary.html

AHCCCS and its contractors have been working to improve the accuracy of physician diagnosis coding. The CMS crackdown on diagnosis coding should also help improve diagnosis coding accuracy on AHCCCS claims and encounters.